

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12054

12024

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Showell</u>	c. LENGTH OF STAY IN 1b <u>60 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Showell</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Bertha C. Baker</u> First Middle Last		4. DATE OF DEATH <u>Oct. 18</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 13, 1876</u>
9. AGE (In years, last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward James Collins</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Lockwood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hazel Rust</u> Address <u>Showell, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chr. myocarditis (acute attack lasted 2 hrs)</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerosis</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>—</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 18, 1960</u> , to <u>Oct 18, 1960</u> , that I last saw the deceased alive on <u>Oct 18, 1960</u> , and that death occurred at <u>11:54 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Frank Lewis</u> M.D. <u>Millards Maryland</u> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/20/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows</u>	22d. LOCATION (City, town, or county) (State) <u>Bishopville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Watson</u> ADDRESS <u>Pocomoke City, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>OCT 25 '60</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>



12055

CERTIFICATE OF DEATH

12025

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berlin Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berlin Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>Rural</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>O.</b> Last <b>Cordery</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>7,</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 6, 1876</b>
9. AGE (In years last birthday) yrs. <b>84</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Employee Delaware State Highway</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Delaware</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph W. Cordery</b>		14. MOTHER'S MAIDEN NAME <b>Lavenia Phillips</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>221-09-6758</b>	
17. INFORMANT <b>Mrs Julia Cordery, Berlin, Md. R. D.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Debility</b> DUE TO <b>191-2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Carcinoma of Face involving nose &amp; Rt cheek.</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs 5 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1958</b> to <b>Oct 7, 1960</b> that I last saw the deceased alive on <b>Oct 7, 1960</b> and that death occurred at <b>9 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Hermon A. Radley</b> M.D.		ADDRESS (Street, city or town, state) <b>Berlin, Md.</b> DATE SIGNED <b>10/7/60</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 10, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mechanic's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Millsboro, Del.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William E. Latham, Jr.</b>		ADDRESS <b>Georgetown, Del.</b>	
24a. REC'D BY REGISTRAR <b>OCT 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1935

1935

Name of Deceased		Date of Birth		Sex	
John Doe		Jan 1, 1900		Male	
Place of Birth		Date of Death		Cause of Death	
New York City		Jan 15, 1935		Heart Disease	
Occupation		Marital Status		Burial Place	
Teacher		Married		Catholic Cemetery	
Signature of Physician		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Death		County	
Jan 15, 1935		New York City		New York	

1935

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12050

12026

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berlin</b>		c. LENGTH OF STAY IN 1b <b>8 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Old Rt 50</b>				d. STREET ADDRESS <b>206 W. London</b>		9212-2	
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>BELLE</b> Last <b>DENNIS</b>				4. DATE OF DEATH Month <b>10</b> Day <b>18</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-11-1877</b>		9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Garrison Adkins</b>				14. MOTHER'S MAIDEN NAME <b>Melinda Truitt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Mrs. E. Linwood Taylor, Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Dilated Heart</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Age</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-18-1960</b> to <b>10-18-1960</b> , that I last saw the deceased alive on <b>10-18-1960</b> , and that death occurred at <b>7:15 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Chas. R. Law</b> M.D.				ADDRESS (Street, city or town, state) <b>Berlin Md</b>		DATE SIGNED <b>10-19-1960</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES R. LAW</b>				<b>BERLIN, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-20-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Hope Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Willards, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>				24a. REC'D BY REGISTRAR <b>Norman F. Baker</b>		24b. REGISTRAR'S SIGNATURE <b>Oct 21 '60</b>	

15036

15036

15036

15036

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15036



12056

## CERTIFICATE OF DEATH

12027

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City (Rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>R29</u>			
3. NAME OF DECEASED (Type or print) <u>Elsie Alice Sumner</u>				4. DATE OF DEATH <u>Oct 3rd</u> 19 <u>60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> OR DATE OF BIRTH <u>Oct 1877</u>		9. AGE (In years last birthday) <u>83</u> yrs.	
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cleaning</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Frank Benthingham</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Long</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <u>Tabitha Rock Pocomoke City, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>444X Hemorrhages from bowels</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Menstrual, unbalanced several years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 3rd</u> , 19 <u>60</u> , to <u>Oct 3rd</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Oct 1st</u> , 19 <u>60</u> , and that death occurred at <u>St. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>N.E. Sartorius Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Market St. Pocomoke City, Md</u>			
PHYSICIAN'S NAME (Type) <u>N.E. Sartorius</u>				DATE SIGNED <u>10/3/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-6-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Atlantic, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - new church, Va.</u>				24a. REC'D BY REGISTRAR <u>OCT 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





12057

## CERTIFICATE OF DEATH

12028

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) b. STATE <b>Maryland</b>		b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishop RFD</b>		c. LENGTH OF STAY IN TB <b>6 Months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishopville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>XX</b>				d. STREET ADDRESS <b>XX</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DELLA</b>		First <b>ETHEL</b>		Middle <b>HUDSON</b>		Last	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 13, 1878</b>	
				9. AGE (In years last birthday) <b>82 yrs.</b>		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Davidson</b>				14. MOTHER'S MAIDEN NAME <b>Jane Gault</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>XX</b>		16. SOCIAL SECURITY NO. <b>XX</b>		17. INFORMANT <b>Mrs. Elisha Buntine, Bishop, Md. RFD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) DUE TO <b>Coronary occlusion acute</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Coronary sclerosis</b> (c) <b>Arterio sclerotic (CVD)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 months</b> <b>10 years</b> <b>?</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 13, 1960</b> , to <b>Oct 14, 1960</b> , that I last saw the deceased alive on <b>Oct 13, 1960</b> , and that death occurred at <b>6:20 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Ocean City, Md.</b> DATE SIGNED <b>Oct 17, 60</b>							
ACTUAL SIGNATURE <b>Francis J. Townsend Jr</b>		M.D.					
PHYSICIAN'S NAME (Type) <b>FRANCIS J. TOWNSEND JR</b>							
22a. BURIAL, CREMATION, (Specify city) <b>Burial</b>		22b. DATE THEREOF <b>10/14/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>I. O. O. F.</b>		22d. LOCATION (City, town, or county) (State) <b>Bishopville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peter Whaley</b>		ADDRESS <b>Bishopville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. News</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. BARNHART</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>1900</u></p>	
<p>5. Place of birth: <u>MASSACHUSETTS</u></p>		<p>6. Date of death: <u>1945</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1945</u></p>		<p>12. Office of registration: <u>[Signature]</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 2 may be used by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 filed 10-2-60 et

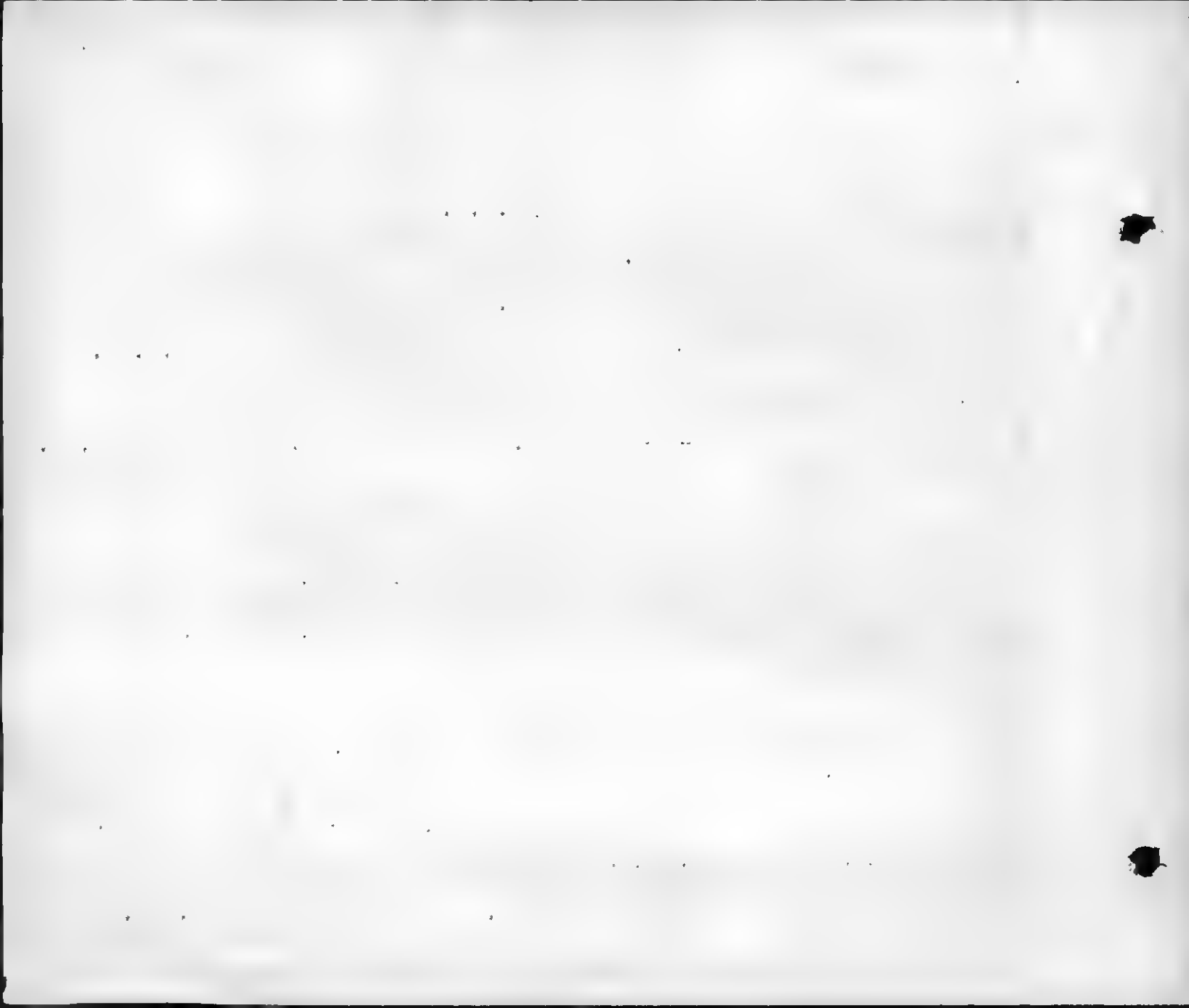
## CERTIFICATE OF DEATH

12029

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>				d. STREET ADDRESS <b>R.F.D.# 3 Box 60</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>W. Jenkins</b> Last				4. DATE OF DEATH Month <b>October</b> Day <b>10</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 31 1887</b>		9. AGE (In years last birthday) <b>72 yrs.</b>	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Solomon Jenkins</b>				14. MOTHER'S MAIDEN NAME <b>Leah Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 1</b>		17. INFORMANT <b>Mrs. Beatrice Wise, Pocomoke City, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Anoxemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis, cerebral and generalized</b> DUE TO (c) <b>Arteriosclerosis, generalized, severe.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b> <b>many years</b> <b>many years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(1) Hypertensive Cardio-vascular disease (2) Hemiplegia, left, complete.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>29, April, 19 60</b> , to <b>7, Oct., 19 60</b> , that I last saw the deceased alive on <b>Oct. 7, 19 60</b> , and that death occurred at <b>12 noon</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>N. E. Sartorius, Jr.</b>				ADDRESS (Street, city or town, state) <b>114 Market St., Pocomoke City, Md.</b>			
PHYSICIAN'S NAME (Type) <b>N. E. Sartorius, Jr., M.D.</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/16/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wardtown Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar Wharton - new church, Va.</b>				24a. REC'D BY REGISTRAR <b>OCT 19 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>	

MEDICAL CERTIFICATION



12053

CERTIFICATE OF DEATH

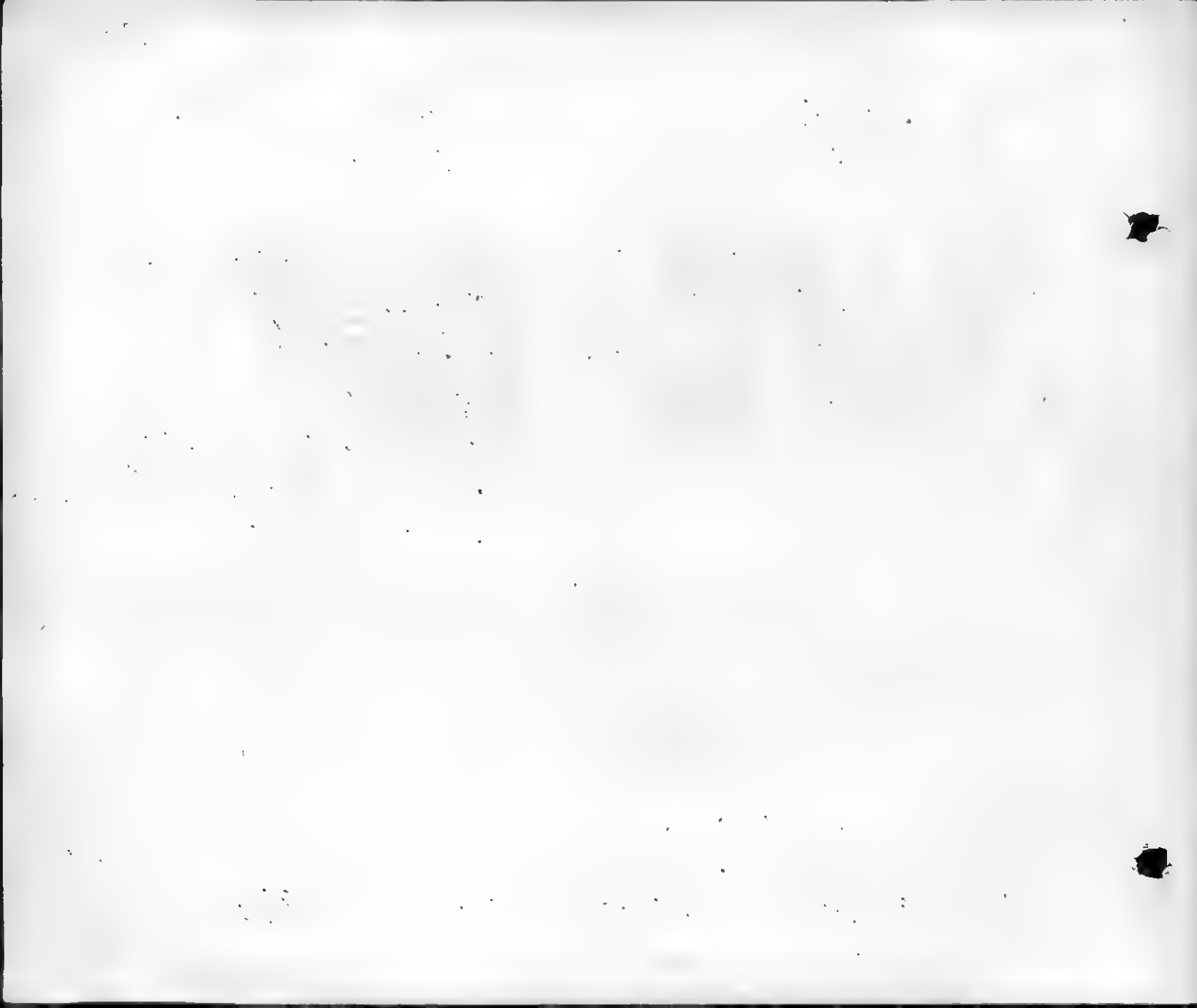
12030

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		c. LENGTH OF STAY IN lb <i>57 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Bertie</i> Middle <i>E</i> Last <i>Kensley</i>		4. DATE OF DEATH Month <i>October</i> Day <i>11</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-4-1887</i>
9. AGE (In years last birthday) <i>72 1/2</i>		10. IF UNDER 1 YEAR Months <i>11</i> Days <i>11</i> Hours <i>11</i> Min <i>11</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Toldeo, Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>J. S. Mac Donald</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Agner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Michael C. Kensley, Snow Hill, md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute Coronary Thrombosis</i> DUE TO (b) <i>ASHD (Arteriosclerotic)</i> DUE TO (c) <i>Hypertension. Heart Disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>1-2 hrs</i> <i>years.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-11, 1960</i> , to <i>10-11, 1960</i> that I last saw the deceased alive on <i>10-11, 1960</i> and that death occurred at <i>11 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>David Rafat</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>DAVID RAFAT M.D.</i>		<i>104 Bay St. Snow Hill</i>	
22. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried Oct 14/60</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Christian Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Snow Hill md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wayne G. Jones</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 14 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





3-18-85

VS A15 (4)  
15M 10/57



12059

## CERTIFICATE OF DEATH

12032

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BISHOP MD.</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANGIE</u> Middle <u>MURRAY</u> Last <u>SAVAGE</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 5-1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>ANNENEHAS MURRAY</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE BISHOP</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>EVA LEWIS -</u>		Address <u>SELBYVILLE, DEL.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal carcinoma</u> <u>159X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>probably of C.I. origin</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>about 3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug</u> , 1955, to <u>Oct</u> , 1960, that I last saw the deceased alive on <u>29 Sept</u> , 1960, and that death occurred at <u>4:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl B. McFadden</u>		DATE SIGNED <u>7 Oct '60</u>	
PHYSICIAN'S NAME (Type) <u>Earl B. McFadden</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-10-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ODD FELLOWS</u>	22d. LOCATION (City, town, or county) (State) <u>BISHOPVILLE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H Watson</u>		ADDRESS <u>Tocomahe Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO BE COMPLETED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (M)  
15M 9/59

12051

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12053

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> <u>Ocean, City</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean, City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Milford, Del.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>46x-3</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Wibb</u> Last <u>Wibb</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 18, 1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delaware</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Willard Breeding</u>		14. MOTHER'S MAIDEN NAME <u>Stafford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Mrs. Bennett Mills Ocean City, Md.</u>	
17. INFORMANT <u>Mrs. Bennett Mills</u>		Address <u>Ocean City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema &amp; Sen. Anasarca</u> 42.0.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocarditis &amp; Coronary Sclerosis</u> DUE TO (c) <u>Generalized Atherosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 yrs</u> <u>10 yrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1958</u> to <u>Oct 7, 1960</u> that (I) (we) last saw the deceased alive on <u>Oct 7, 1960</u> and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard Dallas</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Herbert A. Robbins</u>		22d. ADDRESS <u>Bladen, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 10, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows</u>		23d. LOCATION (City, town, or county) (State) <u>Milford, Del.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burby</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 17 '60</u>	
ADDRESS <u>Berlin Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>	

1841

1841

(1)

(1)